Intergovernmental Transfer Questionnaire

Part A: General Information

Georgia Department of Community Health

1. **Identification:**

Facility UID Year

a. Facility Name b. County

c. Street Address d. City e. Street Zip

e. Dates (beginning and ending) of most recently completed Fiscal Year through

Part B: Electronic Signature and Contact

I hereby certify that I am authorized to submit this form and that the information is true and accurate. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature Date

Person authorized to respond to inquiries about the responses to this survey:

Name Title

Telephone: Fax E-mail

Part C: Ownership

1. Check the box to the right if the owner is a governmental entity. ☐
   If yes, please specify the type of government owner using the pull down menu below.

2. Which legal entity owns title to your healthcare facility?

   Name

3 Check the box to the right if there is a copy of the deed or other evidence of such ownership available on request ☐

Part D: Lease Arrangements

1. Check the box to the right if the facility is currently being leased or managed by a private entity. If yes, please provide the legal name, year lease/management began, and year the lease expires. ☐

   Name

   Year Lease/Management Began

   Year Lease Expires

2. **Please answer the following pertaining to question D:1. Check the box to the right if applicable.**

   a. The Lessee is a nonprofit, charitable corporation. ☐

   b. The governmental entity which owns the facility helped create the Lessee entity by assisting, supporting or participating in its incorporation. ☐

   c. Members or directors of the owner's governing body or the governing body of any other governmental entity serve on the Lessee's board of directors. ☐

   d. Representatives of the Lessee meet with representatives of the governmental entity which owns the facility for the purpose of sharing information and ideas regarding operation of the leased facility. ☐

   If applicable, please explain in the text box below.

   e. The facility and other related assets revert to the owner at the end of the Lease. ☐

   If applicable, please explain in the text box below.

3. Under the Lease, what rights have been reserved to the governmental entity which owns the facility? (For instance, does the Lease require that members or appointees of the owner serve on the board of the Lessee or on one or more facility committees, or does the Lease require that the facility be operated exclusively for charitable purposes?)

4. Check the box to the right if the Lessee is required to provide any services to the governmental entity which owns the facility, such as preparing the owner's budget or underwriting any of the owner's operating expenses. ☐

If applicable, please list these services in the text box below.

5. Check the box to the right, if the Lessee is required to operate the facility in accordance with any state statute. ☐ Below, please select an applicable answer(s).

Please check ALL applicable statutes	
Development Authorities Law	◯
Hospital Authorities Law	◯
Conflict of Interest Law (OCGA § 45-10-21)	◯
Open Meetings Law (OCGA § 50-14-1)	◯
Open Records Law (OCGA § 50-18-70)	◯
Other Law (Specify)	◯

6. If the owner is a Hospital Authority, does the Lessee set its rates and charges in a manner which complies with restrictions in the Hospital Authorities Law? ☐

If yes, please explain below.

7. Check the box to the right if the Lease contains any events of default relating to the facility's operations (as opposed to merely the Lessee's failure to pay rent). If yes, please describe these events in the text box below. ☐

Part E: Access to Tax Revenue

1. Check the box to the right if the facility or the governmental entity which owns the facility receives any local or state governmental funds or benefits (other than Medicaid or Medicare)? If so, please select each such source and provide the amount or value of such funds or benefits. ☐

Please use amounts received in your most recently completed FY.

Source		Amount
Direct State Appropiation	◯	
Direct County Appropiation	◯	
Direct City Appropitation	◯	
State Health Benefit Plan Payments	◯	
Other state agency health plan payments (e.g. corrections , Human Resources, etc)	◯	
Healthcare Purchasing from Local Governements	◯	
Other (Specify) - 1	◯	
Other (Specify) - 2	◯	
Other (Specify) - 3	◯	
Other (Specify) - 4	◯	

2. **If your facility is owned by a Hospital Authority, please complete 2a.**

   2a. Please indicate the amount of county or municipal tax funds that would be available to your Hospital Authority, if requested by the Authority and assessed by the county or municipal government, to provide medical care or hospitalization for the indigent sick (assume the maximum 7 mills tax for purposes of this question)?

3. **If the owner of your facility is a Development Authority, please complete 3a.**

   3a. Please indicate the amount of county or municipal tax funds that would be available to your Development Authority, if requested by the Authority and assessed by the county or municipal government to provide financial assistance to such Development Authority?

4. Check the box to the right if any of the facility's assets or revenues are pledged to secure any indebtedness incurred by the governmental entity? If yes, please describe the indebtedness and the nature of the pledge or security. ☐

5. If your answer to question E:4 was in the affirmative, using the pull down menu select the best description of how the facility's revenues are collected and placed in reserve in order to comply with the requirements of such pledge or security interest?

If other, please specify in the provided box below:

Part F: Community Services

1. Check the box to the right if the healthcare facility or the governmenrtal entity which owns the facility entered in to an intergovernmental, indigent care or other services contract (e.g., ambulance, medical treatment or training, etc.) with one or more cities and/or counties.

2. Check the box to the right if the facility provides community services and/or indigent care services for the communities served? If yes, list the types of services and the estimate of the value of those services to your community.

Please list each type and value of service.

Type	Value
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0